TGH NEUROMUSCULAR CLINIC REFERRAL REQUEST FORM

FOR CONSULTATION AND/OR
ELECTRODIAGNOSTIC EVALUATION
WITH DR. VERA BRIL AT FAX (416) 340-4189
OR DR. HANS KATZBERG AT FAX (416) 340-4081

(fax required for appointments)

REQUESTED PHYSICIAN (BRIL/KATZBERG) ______________________________

REFERRING PHYSICIAN INFORMATION:

NAME: ______________________________

ADDRESS: ______________________________

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PHONE: ______________________________

BILLING NUMBER: ______________________________

REFERRING DOCTOR'S SIGNATURE: ______________________________

PATIENT INFORMATION:

PATIENT'S NAME: ______________________________

PHONE (home & work): ______________________________

REASON FOR REFERRAL: Provide an expert opinion on the clinical and/or electrodiagnostic status of the patient's neuromuscular disorder and advise on appropriate treatment.

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APPOINTMENT DATE: ______________________________